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ABSTRACT

Elder abuse has received attention among professionals only recently; consequently, guidelines for identification and intervention strategies for the professional in the clinical setting remain speculative and untested. Because the problem of family violence is multidimensional, no professional can be expected to meet the needs of every member of a violent family without assistance. To achieve and maintain the safety of family members and maximum intervention results requires a multidisciplinary and coordinated effort by professionals. Clinical practice with abusive families requires a non-judgmental approach and the establishment of a trusting, and possibly long-term relationship. In addition to negative attitudes on the part of professionals, a number of factors can impede successful intervention, including problems of identification and age discrimination. Assessment for elder abuse involves both history taking and a physical examination. To do this effectively, the professional must be open, honest, nonjudgmental, supportive, and compassionate. The objective of interventions must be toward prevention, which can be defined in three stages: primary, to strengthen and enhance the individual; secondary prevention, which includes screening, identification, and treatment to decrease severity of impact; and tertiary prevention or rehabilitation. Research on elder abuse must move toward a systematic program to test and develop theories of family violence. (The appendices provide a listing of possible indicators of elder abuse for use in history taking and the physical examination.) (JAC)

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CLINICAL INTERVENTION WITH THE ABUSED ELDERLY AND THEIR FAMILIES

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CLINICAL INTERVENTION WITH THE ABUSED ELDERLY AND THEIR FAMILIES

The recognition of family violence as a major health problem is gaining the attention of professionals that it has long deserved. Abuse is now commonly recognized to be committed against children. Less familiar is the violence that is inflicted on women by husbands, former husbands, boyfriends, and former boyfriends within the context of the family. It is only recently that abuse and neglect of elderly persons has received attention among professionals. The result is that the necessary theoretical formulations and empirical validations in the area of abuse of the elderly lags far behind that of other areas of family violence. Subsequently, guidelines for identification and strategies of intervention for the professional in the clinical setting remain generally speculative and untested. However, if one accepts the premise that violence in families is not an isolated, one-time-only act and that it involves more than just two members, then a framework for clinical practice and elders in violent families can be derived from what is known about other types of family violence. The purpose of this paper is to describe an approach to clinical practice with abused elderly persons and their families. Though the authors come from primarily a nursing perspective, the presented outlines and interventions can clearly be adapted to the practice in other concerned professions. In addition to the the actual suggested clinical application of knowledge of family violence, areas in need of further research are identified.

The problem of family violence is multidimensional. No professional can be expected to meet the needs of every member of a violent family in every respect without assistance. Rather, violent families require a broad range of

interventions and team work. Many professionals are likely to have contact with the members of the violent family. This may especially be the case when a member of the family is an elder. Chronic health problems may require frequent visits to a variety of health care providers. Limited financial resources and use of state and national assistance programs can involve several different professionals in multiple agencies. Once identified as abusive, the elder and family may receive intervention from social workers, physicians, lawyers, police officers, dentists as well as nurses. According Eli H. Newberger (1976), a physician, the necessary involvement of professionals from different background can result in difficulties. "Each professional does what he or she can, within the ethical definition of his domain. Yet the family and its individual members can be harmed - not helped - by these well-intended, independent actions" (Newberger, 1976, p.15). It is thus necessary that one professional serve as a coordinator of these varied interventions. We would like to suggest that whoever the most access to the whole family and ideally to the home is in a prime position to initiate, coordinate, and evaluate the multidisciplinary approach to the care of violent families. In many cases this would be a public health or visiting nurse, in others a social worker. When the setting, agency, family, and situation indicate that another professional would be better suited as coordinator, it is suggested that the nurse still be an integral member of the team. In any case, the complex phenomenon of family violence necessitates the involvement of numerous professionals and a coordinated approach to achieve and maintain the safety of the members and attain the maximum results from interventions.

Self-Awareness

Clinical practice with abusive or potentially abusive families begins with the professional's examination with his or her own feelings concerning the problem of domestic abuse. A non-judgmental, helping approach to any client requires awareness and resolution of personal feelings that interfere with client/family-professional interaction. The establishment of a trusting relationship, possibly long-term, will be shown to be essential to successful identification of and intervention with abused elders. Professionals who react with anger, disbelief or denial to the prospect of elder abuse or neglect cease to be therapeutic and may, in fact, be detrimental to both the elder and family.

Mechanisms for assisting professionals to become self-aware with relation to violence and socially unacceptable acts would ideally begin during the professional education process. Dorothy E. Rielly (1978), a nurse scientist and educator, suggests that nurses, and the same can be said for other professionals, have a responsibility to deal with all the needs of clients within the guidelines of ethics and the standards of practice. Professional education, therefore, has an obligation to prepare students to meet this responsibility. Rielly (1978) suggests that the appropriate mechanism to prepare such professionals lies in the regular inclusion of learning experiences in the affective domain as well as educational opportunities in the cognitive and psychomotor domains. Reilly further suggests that in order for the learning of values and the resulting self-awareness to take place, two criteria must be met in teaching experience with the phenomenon as it occurs in the real world and critical thinking about that experience to relate it theory and research.

Two research studies with practicing nurses and undergraduate student nurses reinforce the importance of exposure to victims of violence as a factor in value development and subsequent nonjudgemental attitudes. In an investigation of staff nurses' reactions toward rape victims vs. nonsexual beating victims, Cheryl S. Alexander (1980) found no significant difference in nurses' perception of victim blame for either group. The practicing nurses did not attribute a significant degree of responsibility for the crime to either type of victim. In a different study, Shirley Petchel Damrosch (1981) found that graduating baccalaureate nurssing students were significantly more likely to attach responsibility for rape to the victim if the woman committed a perceived act of carelessness (failed to lock her car door). When the students were told the study results, their reaction was one of surprise that they, as a group, had discriminated against the careless victim. As Damrosch points out, the key difference between her study sample and that of Alexander's may be the subjects exposure to victims of violence. The same kind of attitudes can be expected to inhibit professionals working with the abused elderly and their families. Professionals face the same dilemma as do most people: there is a tendency to want to find a way that all victims of violence could have somehow avoided their misfortune because of a need for rational explanations for horrible events, "a just world." (Syminds, 1975). Thus, we all want to "blame one victim", in Ryan's terminology (Ryan, 1971).

Other factors can further impede successful intervention. Even more than other types of family violence, abuse of the elderly may not be identified as an existing problem by professionals and/or agencies. Results of the Institute of Gerontology study (IoG) (Sengstock & Liang, 1982) indicate

the uneven quality of service provided by different agencies. Some health care institutions were quite likely to observe elder abuse while others avoided the problem; religious institutions were mentioned by some elders as being unsympathetic, yet some churches and ministers referred cases to the investigators. The IoG study recognized that a major factor in the identification of and delivery of service to abused elderly was the concern and interest of the professional and agency on the case. Though agency policies and guidelines appeared to contribute somewhat to the service provided to the abused elders, it was not the most important element. Within the same agency some professionals avoided the problem while others did not. Rather, the IoG study found that the individual professional's awareness and concern proved to be the major element contributing to the abused elder's receipt of services.

A final aspect to be considered as affecting the professional's achievement of self-awareness and, thus, readiness to successfully deal with elderly abuse was discrimination due to age. In large part because of Western Culture's lack of value placed on aging, when a client reaches a certain chronological age he or she is categorized as "old" and almost automatically, respect for that person is diminished. The person becomes less of a useful, contributing member of society in the perception of many: family, professional and public alike. In some settings the abused elder may not be identified secondary to the professionals belief that the victim "must be senile" or in some other way have lost his or her senses. As will be discussed in some detail later, the elder is very apprehensive to reveal the abuse or neglect to anyone. All victims of family violence have in common the very real fear of exposure, loss, and abuser retaliation. If anything, reported cases of abuse

and neglects are far outnumbered by those that go unreported. Most professionals who would become irrate and immediately take action upon being told of physical abuse by a 7 year old victim. The same professional may assume senile dementia when given the same history by an 83 year victim. This presents a very critical problem for the abused elder.

Professionals working with the elderly must have examined and dealt with their feelings about abuse and neglect and the victims of such if they are to take the first step toward its prevention. The professional must consider the possibility that maltreatment of the elderly may occur in any family. This is not to say that abuse and neglect of the elderly will always occur. Yet, if professionals are interested in prevention, it makes sense to acknowledge the possibility that every family member has the potential to be a perpetrator and every elder a victim of abuse and neglect. This belief allows professionals to approach their practice as prepared and able to assess the possibility of elder abuse and neglect as they would any other aspect of concern to their practice. As with many other socially unacceptable facts, no family members will acknowledge the maltreatment of an elder unless he or she has had the opportunity to discuss it. No professional will give the elder or a family member the opportunity to ask for assistance if he or she does not accept the possibility that every family has the potential for problems. No elder maltreatment will be found by the professionals who cannot deal with their own feelings or never suspects that elder abuse and neglect do occur.

ASSESSMENT

Assessment for abuse against an elderly person involves two phases: 1) history taking, and 2) physical examination. Certain professionals

may not possess skills in both of these areas in which case the need to assess for elderly abuse in a multidisciplinary manner becomes even more important. Where coordination with professionals from other disciplines involves referral and communication with other agencies, follow-up becomes especially important.

Developing Trust

Assessment for elderly abuse, regardless of the discipline of the professional, requires that a trusting professional-elder relationship be established at the outset. The task of obtaining an accurate assessment of abuse in an elderly client requires that the professional overcome a number of formidable obstacles. As with other kinds of family violence, the victim is often fearful of admitting that abuse has occurred. The elderly client may fear reprisals from the abuser if he or she tells anyone about the abuse. The client may also fear abandonment by the family if the abuse is made known to others. These fears are very real to the elder and may in fact prove out if precautions are not taken by the professional. In addition, the elder, as with other victims of family violence, may be unable to see the acts of family members directed against them as abuse and/or neglect. The inter-generational transmission of violence has been identified and may further contribute to the elders' belief that their treatment is "normal" and/or "their lot". The professional is called upon to use all the tools of their discipline to establish a relationship, often of long standing, that will give the elder every chance to acknowledge and work to overcome the maltreatment they experience. Though the methods used by various professionals may differ, some suggestions can be made as to techniques that are particularly helpful in the development of trust.

Interviewing Techniques

Elderly clients, as with other victims of family violence, must believe that the professional does not stand judgement of them for being in or remaining in an abusive situation. They must also believe that the professional has a genuine desire to help them and will not reveal their difficulty to authorities against their will. Consequently, any aged client with a possible vulnerability toward abuse must be approached by the professional in a nonthreatening manner. Appropriate use of therapeutic interviewing techniques will encourage elderly clients to talk freely and openly about themselves and their family.

From the moment of his or her first contact with the elderly client and family, professionals should present themselves in a manner that is open and honest. The setting for the interview with the elder and/or family should ideally be quiet and private. The specific description of the professional's purpose early at the outset help to allay some of the elder's and/or family's fears and also sets the framework for the professional-client encounter. This is not to say that the professional should accuse either the elder or the family of involvement in family violence. Rather, the professional's early identification of self and purpose makes the relationship between client and professional clear at the outset. A simple statement like "Hello Mr. G. I'm J.B. I'm a clinical nurse specialist. What that means is that I will be taking a personal history from you as well as doing a physical examination today" defines the parameters of the interaction. As the client begins to see that the professional's representation of the interaction was, in fact, the truth, the elder's anxiety is further decreased.

The professional continues to be supportive and compassionate throughout

his or her questioning. Detailed interviewing and about sensitive subjects can be difficult for the elder. If the elder is too threatened by the approach of the professional, he or she is unlikely to be completely open. The professional, in turn, gives the elders every opportunity to share concerns or problems they are experiencing while remaining cognizant of possible threats to the elder's safety.

Every interaction with the elderly client should begin with the concerns of the client. These concerns are likely the reason the elder sought out assistance to begin with. The professional, by giving the elder's concerns or problems of primary importance, is demonstrating that he or she is interested in and values the elder's opinion. The initial inquiry can be as simple as "Is there anything in particular that you are concerned about?"

As the professional and elderly client progress through the interview, the provider avoids being accusatory or confrontive. Clinical experience with victims of family violence has revealed that giving clients an opportunity to voice areas of need or concern can be far more productive than any confrontation.

The power of listening can never be underestimated. The professional can make great progress in data gathering and establishing trust with the elderly client by just listening. Abused and neglected elders are often isolated physically and socially from other people. The opportunity to voice their worries and fears to a compassionate listener can actually be therapeutic for the elderly client.

If the elderly client is brought to the agency by his or her family, it is essential to interview the elder with the family members present at times and absent at others. The interaction between the elder and family members can be particularly informative. Fearfulness of certain family

members on the part of the elder, detachment between elder and family, berating of the elder by family members are all "at risk" findings that may appear during the group interview.

History and Physical Findings Indicative of Maltreatment

Abuse and neglect of the elderly is a topic that has only recently received attention from researchers and service providers. Due to the relative "newness" of the area, research on elder abuse is limited to several respect. Theswe limitations make it difficult to generate a universal tool for the identification of elder abuse. Fortunate[illegible] as the other papers in this symposium have discussed, work is underway to develop instruments which will assist professionals in the identification of elder abuse. In the meantime, suggestions are made in this paper and they must be viewed as tentative. It is fairly certain that the description of possible symptomatology is representative of elder abuse cases studied to date.

Appendix A and B are presented as lists of historical and physical findings which should cause the professional to suspect abuse. Obviously, professional discretion is called into play in the interpretation of these findings in the elder and his family. As can be seen, a number of indicators found in the client's history may be suggestive of abuse, but when taken as independent entities may not support the suspicion that the client is being victimized by family and/or friends. For example, a chronic physical disability may not indicate that an elderly person is at risk or has been abused. Even fractures or extensive bruising may not be clear indicators of abuse. In such cases, the client should be further observed for other possible indicators of abuse. A matrix of several at risk findings should raise the index of suspicion and lead to detailed inquiry into other areas which may indicate risk.

The problem of using physical findings when assessing an elderly person for the presence of abuse deserves special attention. While physical indicators appear to be among the most valid symptoms of abuse or neglect in the child or middle-aged person, it has been noted that apparent symptoms of abuse in an elderly person may in fact be due to the aging process (Ham, 1981; Sengstock & Barrett, 1981). Richard Ham's (1981) discussion of the problems of identifying physical abuse of the elderly observes that the normal physiological processes which govern normal aging lead to physiological changes such as increased capillary fragility, osteoporosis, poor balance, poor vision, mental confusion, and musculoskeletal stiffness among others. Ham suggest that because the elderly are thus more prone to serious injury from minor accidents, they may in fact appear abused when they are not. He further states that conditions such as senile dementia may cause the elder to have delusions regarding their treatment and therefore erroneously report maltreatment. Ham goes on to warn against "falsely diagnosing" abuse as the cause of suspicious physical and psychological symptomatology. While his observations may be accurate, they also mask a dangerous set of assumptions that must be avoided if aged abuse victims are to be served. The IoG study has shown that victims are often not recognized since professionals tend to observe instances of abuse only when they are actively looking for the problem (Sengstock and Liang, 1982). Too many cases of elder abuse and neglect already go unnoticed. It is essential that the professional, for the elder's sake, ere on the side of suspicion, ask the pertinent questions, examine the physical findings, and once completed, if appropriate attribute the elder's condition to normal physiologic processes. Thus, the elder's needs and the professional's responsibilities have received proper consideration.

INTERVENTION

A nursing perspective of family violence requires that all interventions be aimed toward prevention. For the purpose of this paper the levels of prevention used are those defined by Sherry L. Shamansky and Cherie L. Clausen (1980).

"Primary Prevention is prevention in the true sense of the word; it precedes disease or dysfunction and is applied to a generally healthy population" (Shamansky & Clausen, 1980, p.106). The purpose of primary prevention is to strengthen and enhance the individual. Most often this is accomplished through a variety of health promoting activities. Primary prevention takes place before dysfunction exists; however, it may involve interventions with individuals or families who are considered "at risk".

Political activism is a mandatory role for nurses in changing the social structure so that the elderly are no longer so dependent. Melva Jo Hendrix states, 'the day has long since passed when health care professionals can afford to be apolitical" (Shomansky & Clausen, 1980, p.106). Each individual professional cannot be expected to take on every political cause that has impact on these issues. However, each professional can make one such issue something that she becomes truly involved in and then at least vote and write to elected officials about the rest. The results of organized groups such as the Grey Panthers have shown that political activism is no longer just important, but absolutely essential in representing the views of a long unconsidered and ever enlarging group, the elderly.

Discrimination due to age has long existed in the work setting. Mandatory retirement policies are being called into question as the American population as a whole grows older. Keeping the elderly employed and financially independent cannot stop abuse and neglect by itself. However, the stress of total dependence and inactivity greatly contribute to the difficulties experienced by many elders and their families.

Secondary prevention occurs when some problem or dysfunction has been identified or is suspected. Secondary prevention includes screening programs, problem identification, and treatment which attempts to decrease the severity of impact of a problem.

Establishing a trusting relationship appears to be the most critical component, not only in assessment, but also in the provision of adequate care to aged abuse victims. Clients, especially those who have experienced the trauma of domestic violence, are not likely to accept assistance from professionals unless they believe the care provider is deserving of their trust. Such trust can be fostered, as has already been discussed, through the use of therapeutic interviewing techniques.

Unfortunately, the establishment of a trusting relationship is particularly difficult in elder abuse cases and may require a lengthy time span for development. It is often necessary to establish a long-term relationship with a professional before a feeling of trust is exhibited by the victim. Only then is the victim able to admit that abuse is present, either as the underlying problem or as an additional problem which has been overlooked. One technique that may aid in the development of a trusting relationship is the assignment of one professional at each agency as the primary provider to the elder and his or her family. Frequent contact between one professional and the elder, spread out over time, will increase the elder's feelings of security, a feeling lacking in even the elder's own home. The result can be that even in those situations where other professionals are involved with the elder, the trusted professional can act as a liaison between the victim and professionals from other areas.

The importance of a comprehensive plan cannot be overemphasized. Such interventions must be the result of an on-going process, which is originally

based upon an accurate assessment of the client's condition, developed as much as possible in collaboration with the victim and family, and undergoes constant reassessment and alteration as new observations about the client's needs become evident. Such a plan should prove to be a effective method in the establishment of a trusting relationship as well as in the provision of high quality care to the abused and/or neglected elder.

This is particularly important in those cases in which only short-term care is to be provided, or in cases in which the client is to be assisted by a number of care providers. Other professionals involved in the care of the elder, should be fully familiarized with the plan of care for the client and should be observant concerning other at-risk findings which the client and situation exhibit. These observations should be continually added to the initial assessment of the client in order to obtain an accurate record concerning the client's overall situation.

Family therapy can be considered as one appropriate secondary level intervention. The important of one whole family being involved in one sessions, not just the abused elder and abuser, cannot be overemphasized. Any violence in a family affects all members and the interfamilial transmission of violence suggests that other family members are highly at risk as actual or potential victims and/or perpetrators. Successful models from the literature on wife abuse suggests that a behavioral approach is useful in this therapy and that the abuser must be held responsible for his or her actions (Walls and Courtis, 1981). Programs for battering husbands are also in the process of being instituted based on the premise that if violence toward a family member is learned behavior, educational sessions combined with a group support

atmosphere can be effective in teaching other ways of handling anger (Watts and Courtis, 1981).

An important adjunct to some forms of family therapy can be day care for the elderly family member. Day in and day out responsibility for the care of a dependent elder can place the primary caretaker and the whole family under tremendous stress which contributes to family violence. Day care, or if none is available, a home health aid, can alleviate some of that stress.

"Tertiary prevention comes into play when a defect or disability is fixed, stabilized, or irreversible. Rehabilitation, the goal of tertiary prevention, is more than halting the disease process itself; it is restoring the individual to an optimum level of functioning with the constraints of the disability" (Shamansky & Clausen, 1980, p. 106).

It has been noted that some elder abuse is the result of a long-standing pattern of abuse in the lives of the victims and their families. In such situations, it is unlikely that even long-term intervention will have a substantial impact on the abusive pattern. In long-term abusive patterns and those where the safety of the elder is questioned, the only solution may be the separation of the abuser and the abused. In these cases, the establishment of the victim in a living situation separate from that of the abuser should be seen as a positive step. Examples would be nursing home placement or moving the victim to a senior citizens' residence. Placement with another relative may not be a positive sign in an habitually abusive family because such families tend to foster abuse in all members, and the victim may simply move from one problem situation to another.

RESEARCH IMPLICATIONS

The need for research in the area of elder abuse and neglect is tremendous. Professionals who work with the elder and their families are in an ideal position to make a major contribution to the knowledge base of family violence and yet, with a few exceptions, only occasional studies have been reported. The progress to date in understanding and preventing family violence has been small.

Richard G. Gelles (1980), in a review of research done in the seventies on family violence, identifies several areas of need. Research must move beyond mere descriptive efforts toward "a systematic program of research to empirically test theories and also to use available data to build new theories of family violence" (Gelles, 1980, p.882). Research should test theories unlike much of the current theoretical knowledge which is based upon post hoc explanations of data. Gelles suggests that longitudinal designs be employed to provide greater insight concerning time order, and causal relationships in family violence research. The use of more nonclinical samples would help "to overcome the confusion which leads to public identification of family violence with those factors causally related to violent behavior in the home" (Gelles, 1980, p. 883). Finally, Gelles recommends that data collection and measurement techniques increase in number and diversity. Researchers no longer need to fear that subjects cannot or will not disclose violence in their family.

Causation studies have important implications for primary prevention and need to be continued and expanded, but there is an even greater paucity of research or interventions for violent families as a whole and nothing in the literature to date which addresses interventions for elder abuse. We are truly in unexplored territory; we know that abuse and neglect of elders exist but we have little to guide identification and nothing on which to base practice as professionals. The Sengstock et al. effort is the first step in systematic

identification of elder abuse. As we become more alert to the problem and start to find and work with the affected families we need to carefully test interventions as part of agency policy.

CONCLUSION

Abuse of the elderly has been neglected by professionals and public alike. Child abuse and abuse of female partners, although also inadequately recognized, have received much more attention. Yet the phenomenon of violence in the family is common to all three types of member maltreatment. Although the few studies that have examined the problem of elder abuse have provided some basis for clinical practice, much theory development and research remains to be done.

The attempt has been made to describe clinical interventions for potential or actual victims of elder abuse and neglect. Coming from a nursing perspective, the focus of the intervention has been at three different levels: primary, secondary, and tertiary. At every level the key element in the provision of high quality care to elder abuse victims is the establishment of a trusting and insightful relationship between the victim and the primary care provider.

Finally, the need for additional research is identified and particular areas in need of investigation outlined. Professionals willing to take up this challenge may gain satisfaction from the knowledge that they are forerunners in the development of methods of assistance to elder abuse victims who have heretofore not received the same systematic study as other victims of family violence.

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APPENDIX A

HISTORY OF ELDER - POSSIBLE INDICATORS OF POTENTIAL OR ACTUAL ELDER ABUSE

Area of Assessment	At Risk Responses
I. Primary concern/Reason for visit	-Historical data that conflicts with physical findings. -Acute or chronic psychological and/or physical disability. -Inability to participate independently in activities of daily living. -Inappropriate delay in bringing elder to health care facility. -Reluctance on the part of caretaker to give information on elder's condition. -Inappropriate caretaker reaction to nurse's concern (overreacts, underreacts.)
II. Family Health A. Elder	-Grew up in a violent home (abused as child, spouse; abused children). -Substance abuse. -Excessive dependence of elder on child(ren).
B. Child(ren) of Elder	-Were abused by parents as children -Antagonistic relationship with elder. -Excessive dependence on elder. -Substance abuse. -History of violent relationship with other siblings/and or spouse.
C. Siblings	-Antagonistic relationship between siblings. -Excessive dependence of one or more siblings on another or each other.
D. Other Family Members and Family-Like Relations	-Other history of abuse and/or neglect or violent death.

APPENDIX A

Area of Assessment	At Risk Responses
E. Household	-Violence and aggression used to resolve conflicts and solve problems. -Past history of abuse and/or neglect among family members. -Poverty. -Few or no friends or neighbors or other support systems available. -Excessive number of stressful situations encountered during a short period of time (unemployment, death of a relative or significant other, etc.)
II. Health History of Elder	
A. Child	-History of chronic physical and/or psychological disability.
B. Midlife	-History of chronic physical and/or psychological disability.
C. Nutrition	-History of feeding problems (G.I. disease, food preference idiosyncracies). -Inappropriate food, drink or drugs. -Dietary intake that does not fit with findings. -Inadequate food or fluid intake.
D. Personal/Social	-Caretaker has unrealistic expectations of elder. -Social isolation (little or no contact with friends, neighbors or relatives; lack of outside activity). -Substance abuse. -History of spouse abuse (as victim and/or abuser). -History of antagonistic relationships among family members (between family members in general, including elder). -Large age difference between elder and spouse. -Large number of family problems. -Excessive dependence on spouse, children, or significant others.

APPENDIX A

Area of Assessment	At Risk Responses
E. Discipline 1. Physical	-Belief that the use of physical punishment is appropriate. -Threats with an instrument as a means to punish. -Use of an instrument to administer physical punishment. -Excessive, inappropriate, inconsistent physical punishment. -History of caretaker and/or others "losing control" and/or "hitting too hard."
2. Emotional/Violation of rights	-Fear provoking threats. -Infantalization. -Berating. -Screaming. -Forced move out of home. -Forced institutionalization. -Prohibiting marriage. -Prevention of free use of money. -Isolation.
F. Sleep	
G. Elimination	
H. Illness	-Chronic illness or handicap. -Disability requiring special treatment from caretaker and others.
I. Operations/Hospitalizations	-Operations or illness that required extended and/or repeated hospitalizations. -Caretaker's refusal to have elder hospitalized. -Caretaker overanxious to have elder hospitalized.
J. Diagnostic Tests	-Caretaker's refusal of further diagnostic tests. -Caretaker's overreaction or underreaction to diagnostic findings.
K. Accidents	-Repeated -History of preceding events which do not support actual injuries.

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Area of Assessment	At Risk Responses
L. Safety	-Appropriate safety precautions not taken, especially in elders known to be confused, disoriented, and/or with physical disabilities restricting mobility.
M. Health Care Utilization	-Infrequent. -Caretaker overanxious to have elder hospitalized. -Health care "shopping"
N. Review of Body Systems	

APPENDIX B

PHYSICAL EXAMINATION OF ELDERLY PERSONS- INDICATORS OF POTENTIAL OR ACTUAL ELDER ABUSE*

Area of Assessment	At Risk Responses
I. General Appearance	-Fearful, anxious. -Marked passivity. -Malnourished looking. -Poor hygiene. -Inappropriate dress re: weather conditions. -Physical handicap. -Antagonism and/or detachment between elder and caretaker.
II. Vital Statistics	
A. Height	
B. Weight	-Underweight.
C. Head circumference	
III. Skin	-Excessive or unexplainable bruises, welts, scars, possibly in various stages of healing. -Decubitus ulcers. -Burns. -Infected or untreated wound.
IV. Head	
V. Eyes	-No prosthetic device to accomodate poor eyesight.
VI. Ears	-No prosthetic device to accomodate poor hearing.
VII. Nose	
VIII. Mouth	-Bruising, lacerations -Gross dental caries. -No prosthetic device to accomodate loss of teeth.
IX. Neck	
X. Chest	
XI. Abdomen	-Abdominal distention.

APPENDIX B

Area of Assessment	At Risk Responses
XII. Genital/Urinary	-vaginal lacerations -vaginal infection -urinary tract infection
XIII. Rectal	
XIV. Musculo-Skeletal	-Skull/facial fractures. -Fractured femur. -Fractures of other parts of the body.
XVI. Neurological	-Limited motion of extremities. -Difficulty with speech. -Difficulty with swallowing.